**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-4541.M5**

MDR Tracking Number: M5-05-0985-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-24-04.

The IRO reviewed therapeutic exercises, office/outpatient visits, est., ultrasound therapy, electrical stimulation, massage therapy, aquatic therapy/exercises, hot/cold pack therapy, level IV office visit rendered from 04-12-04 through 07-08-04 that were denied based upon "V".

The IRO determined that all disputed services for dates of service 04-12-04, 04-14-04, 04-15-04 and 04-19-04, chiropractic office visits on dates of service 06-11-04, 06-14-04, 06-17-04, 06-21-04, 06-24-04, 06-28-04, 06-30-04, 07-06-04 and 07-08-04 as well as 2 units of aquatic therapy on each aquatic therapy visit billed **were not** medically necessary. The IRO determined that 2 units of aquatic therapy on each aquatic therapy visit billed as well as the remaining office visits and services during the disputed dates of service **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-17-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT code 97124 (18 DOS) 03-22-04, 03-24-04, 03-25-04, 03-29-05, 03-31-04, 04-01-04, 07-01-04, 07-12-04, 07-14-04, 07-15-04, 07-21-04, 07-22-04, 07-26-04, 07-28-04, 07-29-04, 08-02-04 and 08-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. The MAR per the Medicare Fee Schedule is $26.28 ($21.02 S 125%). The requestor billed $25.70 for dates of service 03-22-04, 03-24-04, 03-25-04, 03-29-05, 03-31-04 and 04-01-04 in dispute. Reimbursement for dates of service 03-22-04 through 04-01-04 is

recommended in the amount of **$154.20** ($25.70 X 6 DOS). The requestor billed $26.28 for dates of service 07-01-04 through 08-04-04 in dispute. Reimbursement for dates of service 07-01-04 through 08-04-04 is recommended in the amount of **$289.08** ($26.28 X 11 DOS).

Review of CPT code 97110 dates of service 03-22-04, 03-24-04, 03-25-04, 03-29-04, 03-31-04, 04-01-04, 04-08-04,04-09-04, 07-21-04, 07-22-04, 07-26-04, 07-28-04, 07-29-04, 08-02-04 and 08-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs, however, recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation. No reimbursement is recommended.

Review of CPT code 99213 (19 DOS) 03-22-04, 03-24-04, 03-25-04, 03-29-04, 03-31-04,04-01-04, 04-08-04, 04-09-04, 07-01-04, 07-12-04, 07-14-04, 07-15-04, 07-21-04, 07-22-04, 07-26-04, 07-28-04, 07-29-04, 08-02-04 and 08-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for EOBs. The MAR per the Medicare Fee Schedule is $61.98 ($49.58 X 125%). The requestor billed $59.00 for dates of service 03-22-04, 03-24-04, 03-25-04, 03-29-04, 03-31-04,04-01-04, 04-08-04 and 04-09-04 in dispute. Reimbursement for dates of service 03-22-04 through 04-09-04 is recommended in the amount of **$472.00** ($59.00 X 8 DOS). The requestor billed $61.98 for dates of service 07-01-04 through 08-04-04. Reimbursement for dates of service 07-01-04 through 08-04-04 is recommended in the amount of **$681.78** ($61.98 X 11 DOS).

CPT code 99080 date of service 04-19-04 denied with denial code "N" (not appropriately documented). The requestor submitted documentation, however, the information submitted does not meet documentation criteria. No reimbursement recommended.

Review of CPT code 99070 date of service 04-23-04 revealed that neither party submitted an EOB. Per Rule 133.307(e)(2)(A) the requestor did not submit a copy of the services billed. No reimbursement recommended.

Review of CPT code 97032 date of service 07-01-04 revealed that neither party submitted an EOB.
Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended per the Medicare Fee Schedule in the amount of **$18.73** ($14.98 X 125%).

Review of CPT code 97035 (11 DOS) 07-01-04, 07-12-04, 07-14-04, 07-15-04, 07-21-04, 07-22-04, 07-26-04, 07-28-04, 07-29-04, 08-02-04 and 08-04-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of

carrier receipt of the providers request for an EOB. Reimbursement is recommended per the Medicare Fee Schedule in the amount of **$162.91** ($14.81 X 11 DOS).

Review of CPT code 97113 (16 units) 07-01-04, 07-12-04, 07-14-04 and 07-15-04 revealed that neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Reimbursement is recommended per the Medicare Fee Schedule in the amount of **$622.56** ($31.13 X 125% = $38.91 X 16).

This Decision is hereby issued this 26th day of January 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

**ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 03-22-04 through 08-04-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule133.307(j)(2)).

This Order is hereby issued this 26th day of January 2005.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Enclosure: IRO Decision

Forté

**7600 Chevy Chase, Suite 400**
**Austin, Texas 78752**
**Phone: (512) 371-8100**
**Fax: (800) 580-3123**

**NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** January 14, 2005

**To The Attention Of:** TWCC
7551 Metro Center Drive, Suite 100, MS-48
Austin, TX 78744-16091

**RE: Injured Worker:**
**MDR Tracking #:** M5-05-0985-01
**IRO Certificate #:** 5242

Forté has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to Forté for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

Forté has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

**Submitted by Requester:**

- Usual IRO notice and documentation
- 12/27/04 note which is a final request for medical dispute resolution
- Explanation of the provider's position regarding the disputed dates of service
- Initial exam followed by multiple re-examinations and re-evaluation reports for dates of service 2/6/04, 3/9/04, 4/6/04, 4/20/04, 4/23/04, 6/7/04, 7/2/04, 7/16/04 and 8/3/04
- MRI report of the right shoulder indicating a supraspinatus tendon tear
- Plain film x-rays of the right shoulder indicating acromioclavicular joint degenerative changes
- FCE reports dated 2/6/04, 3/12/04 and 7/15/04
- Office visits from the chiropractor including treatment notes and descriptions of treatment rendered dated 3/22/04 through 8/4/04 for a total of 36 visits
- TWCC-73 reports from Dr. Howell, D.C., the treating chiropractor, dated 2/3/04 as well as one that was dated 4/20/04. At that point the claimant was pending a right shoulder surgery
- Diagnostic interview prior to work hardening dated 8/5/04
- 4/6/04 note from Dr. Tijmes, M.D., orthopedist
- Prescription for Ultracet and Vioxx from Dr. Tijmes dated 4/6/04
- Document concerning the selection of a designated doctor evaluation dated 4/5/04. The claimant was not found to be at MMI at that point
- Surgical operative note involving the claimant's open acromioplasty and rotator cuff tear surgery dated 5/7/04
- TWCC-69 report from the treating chiropractor stating the claimant was at MMI with 14% whole body impairment rating as of 8/5/04

**Submitted by Respondent:**

- Usual IRO notice and paperwork
- Peer review from Dr. Parsons, M.D. dated 7/3/04
- Chiropractic peer review of 8/14/04 from Dr. Fahay, D.C.

**Clinical History**

According to the documentation submitted for review, the claimant suffered right shoulder pain while trying to open some metal gates in front of the school where he worked as a custodian on ___. It appears the gates did not become unlocked or became caught on something and he pulled his right shoulder during the process. He presented for chiropractic care immediately after the accident it appears or at least on the same day as the accident. The claimant has had orthopedic follow up and has undergone shoulder surgery on 5/7/04. He has seen Dr. Howell, D.C. for pre-operative and post operative physical therapy and chiropractic management. He was placed at MMI on 8/5/04 by the treating chiropractor with 14% whole body impairment rating. It was the chiropractor's opinion at this time that the claimant had not finished his post operative physical therapy, yet the carrier was refusing to make payment, therefore, the claimant was placed at MMI with a rather high impairment rating.

**Requested Service(s)**

CPT codes 97110 therapeutic exercises, 99213 office/outpatient visit, established, 97035 ultrasound therapy, 97032 electrical stimulation, 97124 massage therapy, 97113 aquatic therapy/exercises, 97010 hot/cold pack therapy, and 99214 level IV office visit.

**Decision**

It is my understanding that I was to render a decision regarding dates of service that have been disputed with a "V" code and this seems to include dates of service 4/12/04, 4/14/04, 4/15/04 and 4/19/04 as well as 6/9/04, 6/11/04, 6/14/04, 6/16/04, 6/17/04, 6/21/04, 6/23/04, 6/24/04, 6/28/04, 6/30/04 as well as 7/2/04, 7/6/04, 7/7/04 and 7/8/04. The rest of the services were apparently denied or under consideration due to lack of an explanation of benefits.

I agree with the insurance carrier and find that some of the disputed dates of service were indeed not medically necessary to include all disputed services for dates of service 4/12/04, 4/14/04, 4/15/04 and 4/19/04. Other services not medically necessary were the chiropractic office visits for dates of service 6/11/04, 6/14/04, 6/17/04, 6/21/04, 6/24/04, 6/28/04, 6/30/04, 7/6/04, and 7/8/04. Also deemed not medically necessary were some of the aquatic therapy services. Beginning on or about 6/14/04 the carrier was billed for 4 units of aquatic therapy on each visit. One unit consists of up to 15 minutes of service. Only 2 units of the 4 units billed on each aquatic therapy visit would be considered medically necessary, therefore 2 of the 4 units billed on each visit would not be considered medically necessary.

The remaining office visits and services during the disputed dates of service would be considered medically necessary.

**Rationale/Basis for Decision**

It is my opinion that only 2 units of the aquatic therapy would be considered medically necessary on each visit when aquatic therapy occurred. It was documented time and time again in the chiropractic documentation that 36 minutes out of every hour billed for aquatic therapy on each visit was aimed at non-injury related areas and included various warm up exercises and running backwards and forwards in a pool which did not involve the injured areas. Approximately 24 minutes out of every hour billed was spent in exercising the shoulder. This 24 minutes would comprise between 1 and 2 units or what would be considered by definition up to 2 units of aquatic therapy. Therefore, only 2 units of the 97113 code when it was billed would be considered medically necessary from 6/14/04 through the end of the disputed dates of service of 7/8/04.

As far as the office visits are concerned, it is not medically necessary for an office visit to occur on each and every visit of a post operative physical therapy program. Therefore, I found that the office visits which were billed to the carrier on 6/11/04, 6/14/04, 6/17/04, 6/21/04, 6/24/04, 6/28/04, 6/30/04, 7/6/04, and 7/8/04 were not medically necessary. The remaining office visits which were billed from 6/9/04 through 7/8/04 including the 99214 code which was billed on 7/2/04 would be considered medically necessary. There is no need to see the claimant on every visit of a physical therapy program except for perhaps once per week. The remaining office visits would be considered appropriate. I have arbitrarily picked these dates such that a more reasonable and medically necessary frequency of office visits could be attained. The remaining medically necessary office visits, when taking into consideration the non-medically necessary office visits would comprise about a once per week frequency and that is the reason why these dates were chosen.

As far as the ultrasound, hot/cold packs, electric stimulation and massage which were rendered are concerned, I would consider these appropriate and within the evidence based guidelines recommendations for a post operative physical therapy program. The highly evidence based Official Disability Guidelines recommend about 24 visits over a 14 week period following a rotator cuff repair surgery. This claimant also underwent an open repair involving the acromion which would involve perhaps more physical therapy than would a simple rotator cuff arthroscopic repair.

As far as the disputed dates of service dated 4/12/04, 4/14/04, 4/15/04 and 4/19/04 are concerned, it is my opinion that these services were not medically necessary in that the claimant had already undergone more than a sufficient amount of treatment by this date. In fact well over 25 visits had occurred by this time and this would be more than sufficient given the nature, extent and type of problem treated. It was clear the claimant's range of motion, strength and progress had plateaued as early as the end of February 2004 and therefore these services in April would not be considered medically necessary in that that claimant was pending surgery. The claimant was also given a home based exercise program kit and this would be considered appropriate once it was determined that surgery was medically necessary.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 14th day of January 2005.

Signature of IRO Employee:

Printed Name of IRO Employee: Denise Schroeder